STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
P.O. Box 45010, Olympia, Washington 98504-5010

March 26, 2010

ADSA: NH #2010-001
SUBJECT: REIMBURSEMENT RATES FOR MEDICAID CLIENTS ENROLLED IN MEDICARE

Dear Nursing Home Administrator:

Recently the Department of Social and Health Services undertook a review of how nursing facilities are reimbursed for Medicaid clients who are residing in a nursing facility under Medicare status.

Reimbursement rates for Medicaid clients enrolled in Medicare

For Medicaid clients enrolled in Fee for Service Medicare (not Medicare Advantage plans), Medicare will pay in full for up to the first twenty days of nursing facility care at the full Medicare rate. For the first day and up to eighty days thereafter (i.e., the hundred and first day), the amount paid by Medicare will be reduced by the client's co-insurance responsibility. The department will pay up to the Medicaid rate for the co-insurance days. This is described in WAC 388-502-0110 (3) and WAC 388-517-0320 (1) (d) and 1902 n of the Social Security Act.

Reimbursement rates for Qualified Medicare Beneficiaries (QMB)-only clients

QMB-only clients are not eligible for Medicaid under the categorically needy (CN) or medically needy (MN) programs, but are eligible for payment of Medicare cost sharing expenses.

The department will pay Medicare co-insurance charges for QMB-only residents, up to the Medicaid nursing facility reimbursement rate. It will not be necessary for a QMB-only resident to apply for Medicaid services for payment of co-insurance expenses during Medicare coinsurance days. QMB-only clients are not required to pay participation. They will not be issued a Medicaid award letter. An award letter is not required in order to bill the Department for these expenses. Refer to the nursing home billing instructions at the following link for instructions on how to bill for QMB-only claims:
http://hrsa.dshs.wa.gov/download/BillingInstructions/Nursing_Facilities_BI.pdf

A QMB-only client can be verified for eligibility by reviewing the following information:

Check WaMedWeb for the QMB program (ACES coverage group S03) and no other active medical program. Effective with Provider One "Go Live," review for

this information in the Provider One system. Provider One fact sheet for providers:
http://hrsa.dshs.wa.gov/providerone/Providers/Fact%20Sheets/FactSheets.htm

Reimbursement rates for Medicaid clients enrolled in Medicare Part C (Advantage) plans

For Medicaid clients enrolled in Medicare Part C plans, payment for Medicare days including co-insurance days may vary depending on the Medicare C plan. The department will pay up to the Medicaid rate for co-insurance days.

Medicaid client participation during Medicare days including co-insurance days

Facilities may not collect participation from Medicaid clients during Medicare days, including Medicare co-insurance days. Client participation which is indicated on the DSHS Medicaid award letter is only applicable for Medicaid days. Client participation is not an eligibility factor for Medicare coverage. This includes cases where the Medicaid rate is higher than the Medicare co-insurance rate and DSHS is billed for the co-insurance up to the Medicaid rate. Clients or their representatives are responsible to report if their resources exceed Medicaid standards when clients are in Medicare status as they are not participating toward the cost of care during Medicare days.

Please note the department cannot use Medicaid funds to pay the recipient's co-insurance responsibility beyond the amount Medicaid would pay for the service and cannot allow nursing facilities to write off the unpaid amounts as bad debts on their Medicaid cost reports.

Please contact: Vicki Sutton, Health and Recovery Services Administration (HRSA) at 360-725-2133. E-mail: SUTTOVL@dshs.wa.gov if you have any questions regarding the information contained in this letter.

Respectfully,

Manning Pellanda by MW

Manning Pellanda, Director
Division of Eligibility and Service Delivery
Health and Recovery Services Administration

Ken Callaghan

Ken Callaghan, Office Chief
Management Services Division
Aging and Disability Services Administration

Enclosure: Questions and Answers

cc: Vicki Sutton, HRSA

ATTACHMENT TO DEAR ADMINISTRATOR LETTER 2010-001

Questions and Answers regarding Medicare, Medicare co-insurance days and Medicaid days.

Scenario: Medicaid client discharges to the hospital on 5/5/2010. (In nursing facility from 5/1 until the 5/5/2010 discharge date). Medicaid client returns to the nursing facility on 5/10/2010 under Medicare status for 20 days. The Medicaid client is under co- insurance status from 5/31 until 6/29/2010. First Medicaid day is 6/30/2010. Medicaid client's participation is $1800 per month. Medicaid rate is $180 per day.

Question: How much client participation needs to be collected for the month of May 2010?

Answer: $180 days x 4 days = $720. This represents the "Medicaid days" in the month of May Medicaid does not pay for the day of discharge.

Question: How much client participation needs to be collected for the month of June 2010?

Answer: $180. Client was on Medicare status until 6/29/2010. DSHS can be billed for the co-insurance days in June up to the Medicaid rate. The client's first Medicaid day is 6/30/2010. Therefore, that is the only day in June that client participation can be collected.

Question: Why can't participation be collected for Medicare days in the nursing facility?

Answer: Client participation in the cost of care is an eligibility requirement for Medicaid. It is described in WAC 388-513-1380. Medicare does not have this requirement. When Medicare or a Medicare Advantage plan is the primary payer for nursing facility care, clients with dual eligibility cannot be charged for participation from their monthly income. This applies to periods of full coverage and co-insurance coverage.

Question: Medicare allows facilities to claim Medicare co-insurance days as a bad debt, but does not allow this for individuals on a Medicare C Advantage plan. Can facilities claim these as a bad debt with DSHS?

Answer: No. DSHS does not pay in excess of the Medicaid rate for co-insurance days including Medicare C Advantage co-insurance days. This is not a bad debt with Medicaid.

Question: If a Medicaid client is on Medicare including Medicare co-insurance days, why can't facilities collect client participation or charge an individual for the co-insurance cost?

Answer: Facilities accept the Medicaid rate as payment in full for Medicaid clients. Even if the client is in the facility under Medicare status, the Medicaid client cannot be charged for participation or co-insurance amounts for Medicare days. The client can only be charged participation for Medicaid-only days.